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Care Home Roundtable Report: The Right Medicine

OCTOBER 2016

1. INTRODUCTION

The Royal Pharmaceutical Society (RPS) believes it is time to change the way medicines are used in care homes. Too many care home residents are taking medicines which are doing them more harm than good. At a time when every pound of NHS and social care resource needs to provide value, we believe that a far more efficient system would have a pharmacist, as part of a multidisciplinary team, responsible for the whole system of medicines and their use within a care home. We believe, and evidence shows, that this improves care, reduces NHS medicines waste and reduces the serious harm that can be caused by inappropriate use of medicines.

Pharmacists in care homes can make significant contributions to patient care by delivering effective pharmaceutical care and ensuring that patients use their medicines in an optimal way.

From the presentations and our deliberations on the day, a number of themes emerged, each with actions that can be considered to support the implementation of pharmacists in care homes.

Sandra Gidley,
RPS English Pharmacy Board Chair

"A lot has happened since we launched our campaign to improve the care of people in care homes in February 2016. The positive response we have had from pharmacists, GPs, NHS commissioners and care homes providers has been welcome and reassuring. Most importantly those who represent people who live and work in care homes have provided useful feedback as well as support for our proposals. Now of course there is a need for practical implementation, as co-chair of the NHS England Task and Finish group for pharmacists in care homes I am hopeful we can now move from these warm words of support to actions that can improve care."

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2. BACKGROUND

In February the RPS launched a campaign focused on improving the care of people in care homes through improved medicine use. The main focus of the campaign is to ensure that pharmacists, as part of the multidisciplinary team, should have overall responsibility for medicines and their use in care homes. This will result in significant benefits to care home residents, care home providers, the NHS and social care system.

We have received significant support from people across the health and social care system for this proposal, and most importantly support from those representing older people.

On 11 July 2016 the RPS held a roundtable event where we discussed how we can get the change we are all looking for to become a reality. We bought together a range of key stakeholders to capitalise on the support for the RPS policy and decide how we could act for real change.

The objective of the roundtable meeting was to agree some key actions which can then be collectively owned by those attending.

These included:-

- Using our collective voice to advocate for change
- Thinking about how we can influence local commissioning
- Considering actions to overcome any identified hurdles to implementation.

On 17 December 2015 the Department of Health, working with NHS England, announced a series of reforms for community pharmacy. One element of these reforms is to support the integration of pharmacists into care homes. NHS England is currently taking this work forward.

The RPS would like to thank the speakers who attended the Roundtable event for their contributions on the day.

- Prof Claire Anderson, Vice Chair English Pharmacy Board and Professor of Social Pharmacy, University of Nottingham
- Tony Carson, Pharmacy Advisor, Office of Chief Professional Officers (Pharmacy), NHS England.

We would also like to thank all those who attended and contributed in the day (a list of attendees can be found as Appendix 1).

> **'In 2014, there were an estimated 426,000 people living in residential care homes in the UK and the average age of residents is 85 years. Residents tend to have multiple health conditions and live with a high level of disability'**

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3. PHARMACISTS IN CARE HOMES

How can pharmacists improve care in care homes? An update on latest evidence from Claire Anderson (Vice Chair English Pharmacy Board and Professor of Social Pharmacy, University of Nottingham)

Current situation

Residents in care homes tend to be older than previously with an average age of 85. They are on an average of 7-8 medicines, around 80% of them have dementia and they fall on average 2-6 times a year.

Studies have shown that 70% of residents have at least one medication error every day and that only 10% of older people discharged from hospital remain on the same medicines they were taking on admission. We also know that the risk of adverse drug reactions is 13% with 2 medicines and this increases to 58% with 5 medicines and up to 82% with 7 or more medicines.

The evidence

A randomized controlled trial where a single pharmacist undertook a clinical medicines review with 661 care home residents led to a significant reduction in falls and many medicines related problems were identified and resolved. However, there were no effects on other outcomes such as hospitalisation and mortality. It is difficult to demonstrate this as there are many other influencing factors.

The Care Homes Use of Medicines (CHUMs) study which was published in 2009 provided a lot of the background information. The study showed that 7 out of 10 residents were exposed to at least one medication error (mean of 1.9 errors/resident). This included prescribing errors 8.3% of medicines (39% of residents), monitoring errors 14.7% of medicines (18% of residents), dispensing errors 9.8% of medicines (37% of residents) and administration errors 8.4% (22% of residents).

The study found that the reasons for medication errors was multifaceted. Residents in care homes are treated differently to other people in primary care in that they have less access to specialist services and they often have more transitions between care providers. Care home staff often have a lack of training in medicines, the ordering and dispensing systems for medicines within care homes can often be complex and there is a lack of standardised procedures and documentation to support the processes around medicines. For care home residents the system is often fragmented with poor communication between the different providers of care making it difficult to obtain the 'truth'.

A Cochrane review of interventions to optimise prescribing for people in care homes looked at 12 RCTs (9 cluster, 3 patient) covering 10,953 residents in 355 care homes in 10 countries. They found that diverse, multifaceted interventions (medication review, case-conferencing, education, clinical decision support) were most effective. If such interventions were undertaken, then medication-related problems were resolved and medication appropriateness improved.

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A new study, Care Homes Independent Pharmacist Prescribing Study (CHIPPS), is just starting. This has six stages:

1. Development of service specification
2. Development of outcome measures
3. Health economics
4. Pharmacist training
5. Feasibility study
6. Cluster RCT of 90 care homes and 900 residents

Examples in practice

The Shine study in Northumbria used pharmacist prescribers from the hospital to undertake medicine reviews with residents and their families. For every resident reviewed 1.7 medicines were stopped. This led to a net annualised saving of £184/person and meant that for every £1 invested in the intervention, £2.38 was released from the medicines budget, in addition it saved time on administration of medicines and improved the quality of life for residents.

Leeds West CCG undertook the CHAMOIS Project. Of the 400 residents who were reviewed by a pharmacist 28% required a follow up review, 40% of residents had mismatched allergy records and 1,555 recommendations were made to the GP and 91% of these recommendations were accepted. The gross cost saving was £90,000 and an additional £20,000 was saved on the medicines costs meaning a total of £140 was saved per resident reviewed.

Brighton and Hove CCG contracted with an independent provider to undertake a pharmacist led medicines review with 20,000 care home residents. This resulted in £300,000 of savings due to medicines being stopped in one year and similar savings from avoidance of hospital admissions.

Implementing the future

New models of care can help us all to improve the care of residents in care homes. IT systems need to improve to ensure better access to information for all those who are involved in the care of residents and to enable improved communications. Each care home should have a lead GP and there should be a regular review of prescribing. Each care home should have a healthcare professional with overall responsibility for the medicines and their use, and we believe that person should be a pharmacist.

The RPS believes that pharmacists, as part of the multidisciplinary team, should have overall responsibility for medicines and their use in care homes bringing significant benefits to care home residents, care home providers and the NHS. We also believe that:

- A named pharmacist and a named general practitioner should be responsible for medicines in each care home ensuring coordinated and consistently high standards of care

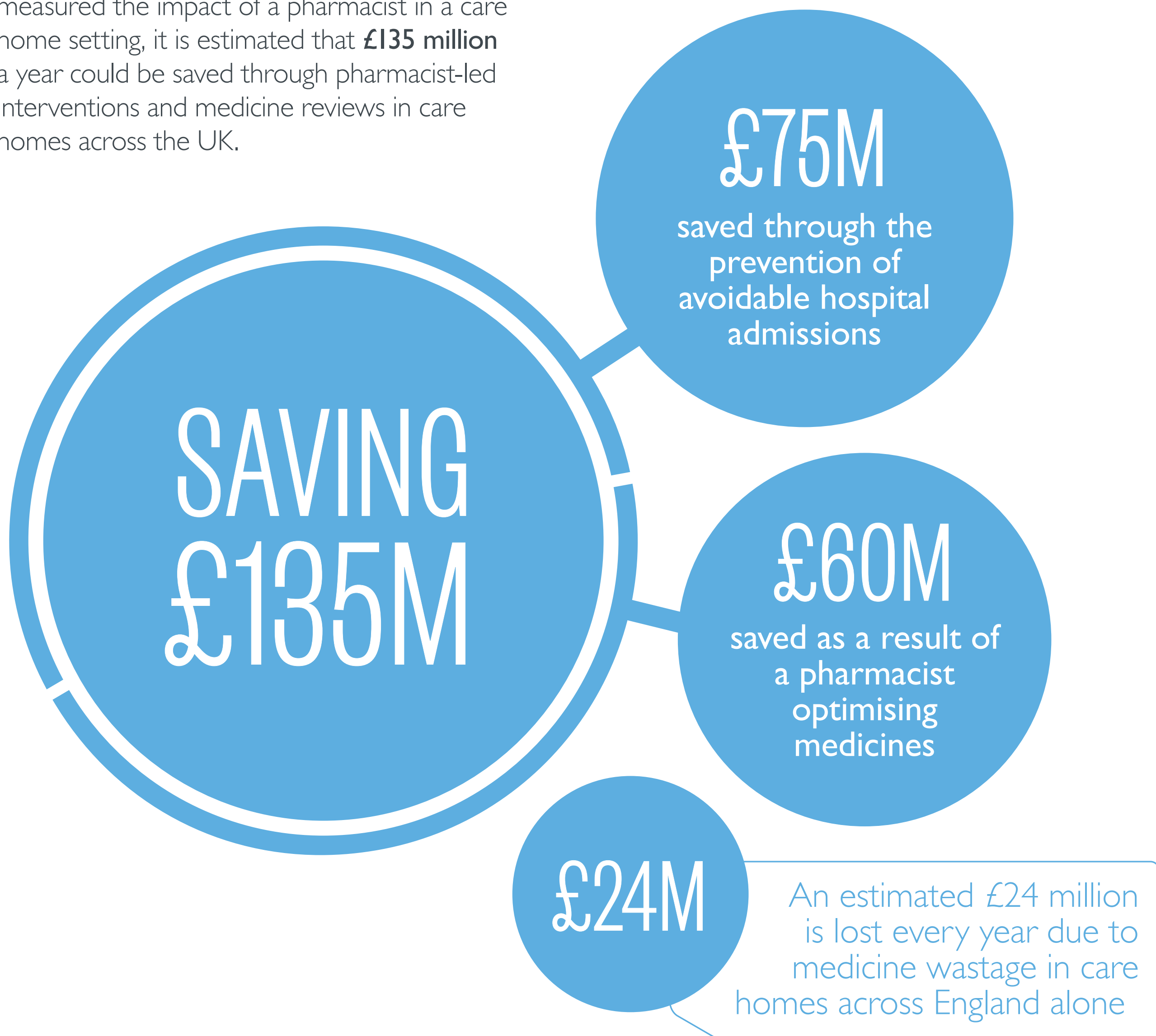
- Where a care home specialises the pharmacist should ensure they have the relevant clinical competency

- Pharmacists should be commissioned by local or national commissioners to provide medicine reviews for care home residents

- Pharmacists should lead a programme of regular medicines reviews and staff training, working in an integrated team, ensuring medicines safety.

Calculating the value of a pharmacist in every care home

Following a review of three local pilots that measured the impact of a pharmacist in a care home setting, it is estimated that **£135 million** a year could be saved through pharmacist-led interventions and medicine reviews in care homes across the UK.



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4. NHS ENGLAND PHARMACY INTEGRATION FUND

How will the NHS England Pharmacy Integration Fund support pharmacists in care homes? An update from Tony Carson (Pharmacy Advisor, Office of Chief Professional Officers (Pharmacy), NHS England)

Background:
The Pharmacy Integration Fund (PhIF) was announced in December 2015. It was created through the community pharmacy review led by the Department of Health (DH) as part of the package of proposals under consideration to transform the way pharmacy and community pharmacy services are commissioned from 2016/17 and beyond. The PhIF is a five year programme, and consists of £20m in 2016/17, rising by £20m per year to £100m in 2020/21, so a total of £300m. The consultation on the overall package of community pharmacy reforms was extended to 24 May 2016, but the consultation on PhIF ended on 24 March 2016.

Pharmacists' skills make them invaluable to patients and the public, but too often those skills are not used effectively. Better utilisation of this resource could mean reductions in avoidable hospital admissions, medicines wastage and sub-optimal care. NHS England has taken important steps to integrate pharmacy into the NHS and the Government would like to make further progress. The PhIF will support a programme of work aimed at accelerating the integration of clinical pharmacy roles, including those provided by high quality community pharmacies with the appropriate skill sets, into primary care, so that they can become an embedded part of wider health and social care.

The consultation responses supported the use of the PhIF to integrate pharmacists into care homes to improve care for residents.

The reason why care homes was chosen as a possible area is that key recent reports have highlighted problems associated with medicines in care homes, and that integrated clinical pharmacy is part of the solution to reducing those problems. Such reports include:

Care Homes Use of Medicines Study
(CHUMS) 2009
http://www.birmingham.ac.uk/Documents/college-mds/haps/projects/cfhep/psrp/finalreports/PS025CHUMS-FinalReportwithappendices.pdf

MDT review of medication in nursing homes
(SHINE) 2012
http://www.health.org.uk/programmes/shine-2012/projects/multidisciplinary-review-medication-nursing-homes-clinico-ethical

Pharmacy and Care Homes
(GPhC) 2015
https://www.pharmacyregulation.org/sites/default/files/pharmacy_and_care_homes_report_by_jo_webber_december_2015.pdf

The Right Medicine: Improving Care in Care Homes
(RPS) 2016
http://www.rpharms.com/promoting-pharmacy-pdfs/care-homes-report.pdf

What services are pharmacists already providing to care homes?
A wide range of pharmacy services are currently provided to care homes by pharmacists and pharmacies. Community pharmacies supply medicines and this is mainly via NHS commissioned services (via the community pharmacy contractual framework). Community pharmacies also provide a range of other services, including:-

- Advice on medicines storage, administration and disposal of unwanted medicines
- Medication administration systems
- Training of care home staff on medicines and medicines related issues
- Clinical advice.

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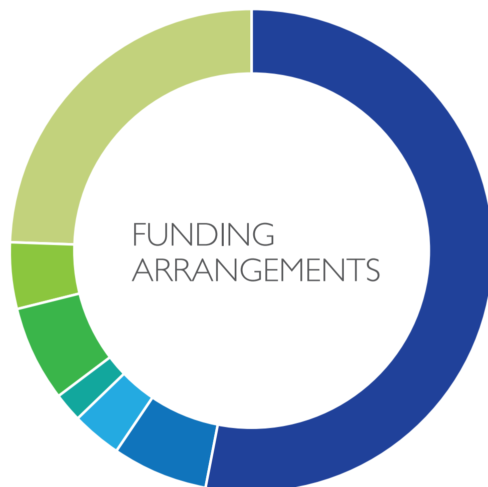
These additional services are provided via a range of funding arrangements and many are not commissioned and are provided via the pharmacy owner at their own expense.

A recent survey by RPS identified over 60 services, with different funding arrangements (see diagram below):



- Clinical Commissioning Group
- Social care or local council
- Hospital provision
- Better care funding
- Care home directly funds
- No additional funding stream
- Other (please specify)

> "That every resident with a long term condition living in a care home environment receives appropriate and timely support from a pharmacy professional to ensure that they get the best use from their medicines."
>
> (Personal view, Tony Carson)

Pharmacy Integration Fund and work to date.
A scoping workshop was held in May 2016 and this was followed by a task & finish group and the first meeting of this group was held in June 2016. This group reports into an oversight group that includes patient and public representation. The task & finish group includes input from a range of experts, including from independent care sectors and it links closely with NHS England Vanguards and the Out of Hospital Urgent Care programme.

Initial proposals include:

- Plans to deploy pharmacists in GP surgeries (focus on those that manage large numbers of care home residents)

- Mapping exercise to better understand the wide range of pharmacy services delivered to care homes across England.

There are obviously a range of interdependencies between the work around care homes and other work supported by the Pharmacy Integration Fund including:-

- Integration of pharmacists into primary care
- Technology to support the development of services and access to information
- Communication
- Prescribing
- Access to records
- Administration systems
- Smart working
- Workforce
- Evaluation.

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5. EMERGING THEMES FROM THE ROUNDTABLE

Here we share the main themes that emerged from the roundtable and follow this with the barriers that those attending the roundtable identified as well as potential solutions.

Medicines reviews

Quite often, as part of a clinical medicines review, a resident's medicines may be stopped. It needs to be recognised by the resident, their family and their carers that deprescribing is not about saving money for the NHS or a reduction of care, but is about making sure all medicines prescribed are appropriate at that time, and that they will provide the best possible outcomes for the patient. The care home staff need to talk about medicine reviews when the person is first admitted to the care home to help them to understand that as a result of these reviews medicines may be changed, started or stopped in order to gain the best possible outcomes for the patient. This discussion could also include the use of a formulary for prescribing. An example was given where tensions developed between care homes residents and their family members, and staff around the use of antipsychotics.

Funding

Any enhanced roles need to be adequately remunerated. The cut in funding for Local Authorities (LAs) has a significant impact on recruitment, retention and continuing professional development (CPD) in care homes. The example was highlighted where the NHS was funding care for cancer patients but not for dementia patients, as this was seen as social care responsibility. The tensions between health and social care funding must be addressed. There is currently regional variation as to what is funded in care homes dependent on commissioners and available funds.

Care Home providers

The Care Home providers were very clear that they need to be involved in the development of any services that involve pharmacists undertaking medicines reviews with residents and leadership in the care home for medicines optimisation. They do not want to feel like these services are being imposed on them. The care home providers are largely unaware of the clinical issues involving the medicines prescribed to the people in their care, and therefore they are not actively seeking a solution. Most are happy to rely on annual GP medicines reviews, which are often conducted remotely.

Care home providers are often not aware of the evidence around the use of pharmacists in care homes. Care home providers are unaware of what a good pharmacy service to a care home should look like and what impact this can have.

Unfortunately care home services are not always driven necessarily by patient need but rather by regulatory requirements and the need to reduce workload due to funding pressures. The administration of medicines has become a huge task and care homes are looking for solutions around this. Nurses in nursing homes are under enormous pressures and are often multitasking when undertaking medicines administration rounds and there is no voice for social care nursing at a central / national level.

Training of care home staff

Care home staff should be made aware of the local formulary used in primary care as they often request medicines that are not on the formulary and this can cause problems for the local prescribers.

Generally, there needs to be better communications across the system, between the care homes and other care providers such as GP practices, community pharmacies, hospitals and intermediate care.

There is quite often a high turnover of staff in care homes so training needs to be ongoing and consistent and delivered to an agreed standard. Currently training is not accredited and there are no recognised standards for care home staff. Training provision on medicines should be standardised and accredited (RPS can accredit) as it is currently very variable. Some training is provided online but needs to be supported with experiential learning.

Training requirements will vary depending on the type of care home. There is more of a need for training of care assistants in residential homes, but nurses in nursing homes have had the training relevant to their role.

It is hard to measure any outcomes, most people are just measuring activity in relation to training rather than the quality and outcomes of the training provision.

A comprehensive resource pack has been developed by the National Care Forum to enable care service providers to improve medicines management, help residents to understand their rights, and to develop safer working practices so that medicines are administered more safely and drug errors are reduced.

General Practitioners

Quite often GPs do not have the time to undertake an in depth medicines review for all care home patients and pharmacists can relieve the burden on them. Pharmacists can improve prescribing for the resident in order for that person to get the full benefits of their medicines.

For example, one GP practice has 200 care home residents and received 70 medication queries on these patients in just one week.

Care homes is an umbrella term for both nursing and residential homes and GPs are often not sure what level of care a patient is receiving.

Pharmacists as prescribers

Some models where pharmacists are being utilised in care homes use pharmacist prescribers whereas other don't. Those where the pharmacist is not an independent prescriber have found that it can actually promote discussion with the GP around decisions and support integration of the pharmacist into the multidisciplinary team.

The value of independent pharmacist prescribers is that they can remove the need for management of diagnosed conditions by GPs and even without the pharmacist being an independent prescriber they can work alongside the GP prescriber to reduce GP workload, and improve relationships.

Lack of uniformity

There is currently no consistent view from LAs commissioners on how care homes should use medicines. It was felt that the CQC core success measures could be useful.

Communication

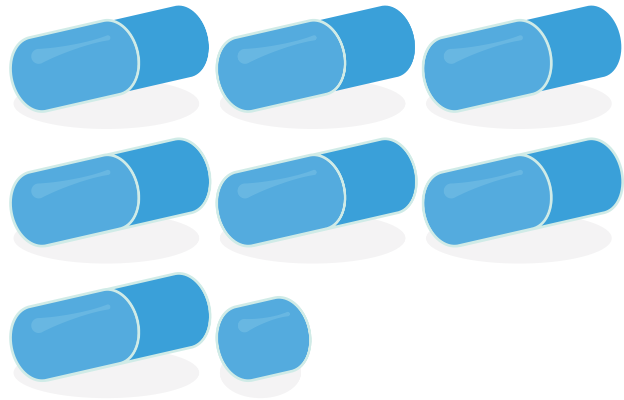
Medical Discharge Summaries are often not sent from hospitals to care homes so care home staff are not aware of any changes that have been made to a resident's medicines. Currently a fax is often the level of IT infrastructure used by pharmacy, GPs and care homes rather than more

sophisticated and integrated IT systems, or even 'simple' solutions such as secure email. Hardware barriers also exist i.e. patchy use of computers in the care home sector.

Information governance for care homes is often seen as a bureaucratic barrier and not proportionate by the care home sector as well as there being a hardware barrier i.e. some care homes don't have internet enabled computers. Work is starting at a national level to try and overcome this with the Care Provider Alliance (umbrella organisation for the independent sector) having a prominent role.

Pharmacists focus on specific areas
A number of different areas were suggested that pharmacists could focus on which would support care home residents. These were:

- Pain management
- End of life care and availability of anticipatory medicines and more training on the use of syringe drivers
- Sepsis
- Acute Kidney Injury awareness needs to be increased so early signs of the condition can be recognised
- Better management of heart failure should also be taught.



7.2 PER DAY

The average age of residents in care homes for the elderly is 85 and they are prescribed an average of 7.2 medicines per day.

97% PRESCRIBED AT LEAST ONE MEDICINE

There are 405,000 care home residents in the UK aged 65+ and experts estimate that around 97% are being prescribed medicine. If a named pharmacist policy was implemented across the UK, then up to £60M could be saved through improved medicines use in care homes.

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6. BARRIERS AND POTENTIAL NATIONAL SOLUTIONS

There is a significant amount of work being undertaken to enhance and improve care for residents in care homes. Areas of good practice need to be spread, adapted and adopted as opposed to re-inventing the wheel. The New Care Models of Enhanced Health in Care Homes vanguard sites are providing some innovative ways of working.

BARRIERS	POTENTIAL SOLUTIONS
Currently there is **no description or national standard model** of what a good pharmaceutical service to a care home looks like meaning commissioners and care home providers do not know what is expected of them or what to commission for.	Develop a national **commissioning guide** for commissioners and care home providers. Focus on recognised issues, such as workload pressures for GPs and care homes, to establish opportunities to provide support where it is needed the most and the opportunity to decrease this. Don't just focus on one model, create multiple models for potential adoption, as there are currently lots of options already working well in care homes and pharmacists in GP practices are not the only solution. Any standards produced must also account for non-elderly residents, who make up a significant proportion of the care home population in the UK. The Vanguard model of **Enhancing health in care homes** has published a national framework. This framework promotes the role of pharmacists. A comparison of **vanguards to non-vanguards** could be undertaken to see the impact on residents and care home providers. Some large pharmacy organisations provide services at their own cost as they recognise there is a need for them but it is difficult to get services commissioned. In order to encourage pharmacists to deliver services to care homes **quality indicators should be included in the national Community Pharmacy Contractual Framework** focused on quality improvements in care homes. Any standards must include input from patient bodies, to ensure that the clarity on the expectations of residents and families are captured and this needs to be delivered upon nationally.

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BARRIERS	POTENTIAL SOLUTIONS
There is no funding available to support those who have committed to providing clinical pharmacists for care homes in terms of education and training.	Explore the use of the Pharmacy Integration Fund to support ongoing education and training for pharmacists in care homes.
There are no metrics available to measure impact on patient care and quality improvement. We can measure impact on prescribing budget but more difficult to measure the wider impact on admissions and readmissions (patient outcomes).	Explore development of **relevant metrics** at a national level with use of the Pharmacy Integration Fund, and take into account any learning from work undertaken in this area by the vanguard sites.
There is no clarification on whether service provision should be funded via the health budget or the social care budget.	In order for pharmacy services to be successful there needs to be pressure and **demand from care homes** for these services. There also needs to be recognition at a national and local level that medicines optimisation is a health issue and not just a problem for social care to deal with. We all need to understand **what business models are available** and who can fund them. Funding is an issue so **alternative funding sources** such as the Better Care Fund need to be explored. There needs to be a recognition that this service is on the basis of invest to save. **Consideration also needs to be given to quantifying** the quality outcomes and savings made, if services are to be commissioned on a national basis. Good practice needs to be **shared, adapted, adopted** and spread.

BARRIERS	POTENTIAL SOLUTIONS
Care Homes are more concerned with CQC requirements and feel over regulated and are actually **not that aware of problems with medicines and polypharmacy**.	Any service or guidance that is developed needs to be developed jointly with care home providers so there is **shared ownership**.
Teams are dynamic at all levels. There is staff turnover in care homes, primary care, GP practices, pharmacies, etc.	**National shared framework** and narrative for patients, relatives, carers, NHS staff, healthcare professionals. This would need to be practical to ensure adoption and needs to be agreed by patient representatives and professional bodies.
Care home staff are trained to different levels and training is inconsistent and not standardised.	**National competency framework for care home staff** followed by national standards and accreditation of training around medicines and their use. This would need to include the new "nursing associate" role and should include administration of medicines. Development needs to involve HEE, CQC and skills for care. **Registration / accreditation** of training for care home staff should be mandatory.
Raise awareness of the national evidence and the benefits of having a pharmacist leading medicines reviews within a care home.	**Production of "benefit" statements** for all stakeholders that answers the question "what is in it for me?" This would need to be tailored for patients, care homes and their staff, GPs and pharmacists and led by RPS. There is a need to **collect and share data** around pharmacy service provision to care homes and it would be good if this could be done nationally and shared locally but bearing in mind the risk of non-acceptance locally. Each locality wants their own data to prove it works but there needs to be a move towards **acceptance of national evidence. The evidence demonstrates real, in-year, tangible savings against the prescribing budget**.

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BARRIERS	POTENTIAL SOLUTIONS
	There needs to be a good **communications strategy** about the services pharmacists can provide and the benefits of these at a national level. Local **Health and Wellbeing Boards** can be utilised to influence the local CCGs to commission a service, but bearing in mind that the HWBs themselves are variable.
Communication between all those involved in the resident's care is fragmented. Implementation of care is via 150 Local Authorities, 200+ CCGs, 1000s of care homes, GPs and pharmacists and care homes staff.	**IT Infrastructure should be enhanced.** Pharmacies are using NHSmail and Summary Care Records and extending the use of similar technology in care homes would have extensive benefits. Developments in information governance are critical if this if to take place. The use of collaborative tools such as Skype consultations should be encouraged.

7. POTENTIAL PRACTICAL SOLUTIONS

Potential practical solutions to support the use of pharmacists in care homes

- Establish a network of care homes for support and learning from each other. Some of this is ongoing via the networks for the Enhanced Health in Care Home Vanguard sites and there are also care home forums which can be utilised.

- Share best practice such as Sutton Vanguard reference cards (Sepsis, Sick Day Rules (in development)) and de-prescribing support. Learn from each other and fast track e.g. learning forums with protected time and space for networking.

- Start small and expand in an area.

- Involvement and education of relatives in decisions, especially knowledge that medicines reviews will happen and medicines may be stopped and this is not to the detriment of the patient. Sick day rules may be a good place to start.

- Develop private sector models.

- Allocate a named GP and pharmacist to each care home and support them to work together. This is not without difficulty and need to guard against this being a tick box exercise.

- Develop a policy statement (leaflet) which is given to all patients and their relatives / carers when they first come into a home stating that medicines will be reviewed and potentially decreased for the person's benefit.

- Work with Sustainability and Transformation Plans (STPs) to ensure that people resident in care homes are a priority.

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8. PERSONAL COMMITMENTS

Attendees on the day made some personal commitments as to how they would try and support the implementation of the RPS policy.

- I will speak to NICE regarding implementing quality standards.
- I will review the prescribing information that we give to care homes to inform prescribing choices.
- I will develop a briefing outlining who you need in a room if considering developing this service in care homes (types of people).
- We will explore the potential of developing a document explaining what pharmacists can do for care homes.
- I will contribute to a secure email quick guide.
- I will focus on the existing standard for the Medical Discharge Summary from hospital and highlight the need for it to be transmitted with consent to Care Homes systematically and quickly.
- I will undertake work with the Professional Records Standards Body and all relevant agencies.
- I will continue to proactively collaborate across agencies at a national level.
- I will introduce a leaflet for patients' relatives on admission into a care homes explaining that medicines will be reviewed and this may mean medicines are stopped.
- I will help to facilitate care home providers to bring one voice to commissioners.
- I will use my teams to support care homes and share the RPS report (The Right Medicine).
- I will advocate for full read/write access to records as this would help momentum.
- I will link more closely with community pharmacist colleagues when reviewing patients in care homes.
- I will help to develop a medicines policy national template.
- I will support a resource on what a pharmacist can do nationally.
- I will attempt to influence NHS England to deliver some quick wins with use of the Pharmacy Integration Fund.
- I will look at NICE quality standard on care homes and see what "quick wins" are available for my team to demonstrate alignment with RPS policy.
- I will explore the probability of having a national database of useful care homes interventions by pharmacists to demonstrate impact and this could be hosted by NHS Business Service Authority or the NHS Atlas of Variation to share learnings and outcomes.
- I will continue to promote and share the current evidence.

THE FINAL WORD

> “This is a hugely important area and I hope that we can make rapid progress with some of the actions. The old and vulnerable need to benefit from the best possible care and if we can get it right for residents of care homes then we will be well placed to tackle the even bigger problem of medicines use in the frail elderly who are cared for at home”.

Sandra Gidley,
Chair, English Pharmacy Board,
Royal Pharmaceutical Society

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ROUNDTABLE ATTENDEES

RPS Team

Neal Patel
Head of Corporate Communications, RPS

Heidi Wright
Practice and Policy lead for England, RPS

Yvonne Dennington
EPB Secretary, RPS

Roundtable Attendees

Sandra Gidley
Chair, English Pharmacy Board, RPS

Catherine Armstrong
English Pharmacy Board member, RPS

Claire Anderson
Vice Chair, English Pharmacy Board, RPS

Deborah Evans
English Pharmacy Board member, RPS

Mandy Nagra
NHS England Senior Manager, Enhanced Health in Care Homes, NHS England

Tony Carson
Pharmacy Advisor, Office of Chief Professional Officers (Pharmacy), NHS England

Tom Gentry
Senior Health and Care Policy Manager, Age UK

Martin Green
CEO, Care England

Sarah Taylor
Chief Pharmacist, Sutton Vanguard

Hai To
Care Home pharmacist, Sutton Vanguard

Jason Axford
Lead Quality Development Manager (North), Residential Care Services, Care UK

Frank Ursell
CEO, Registered Nursing Homes Association

Steven Barrett
Senior Clinical Pharmacist, Northumbria Healthcare NHS Foundation Trust

Keith Strahan
Principle Relationship Manager - Social Care, NHS Digital

Lynne Bowers
Director of Adult Social Services, West Midlands

Malcolm Harrison
Senior Manager, Projects and Contract Development, Boots UK

Lawrence Brad
Royal College of General Practitioners representative

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USEFUL RESOURCES

RPS The Right Medicine: Improving Care in care Homes
http://www.rpharms.com/promoting-pharmacy-pdfs/care-homes-report.pdf

RPS webpage on care home campaign
http://www.rpharms.com/our-campaigns/pharmacists-improving-care-in-care-homes.asp

RPS Ultimate guide for pharmacists working in care homes
http://www.rpharms.com/landing-pages/working-in-care-homes-hub.asp

NHS England The framework for enhanced health in care homes
https://www.england.nhs.uk/wp-content/uploads/2016/09/ehch-framework-v2.pdf

National Care Forum Safety of medicines in care homes resource
http://www.nationalcareforum.org.uk/project-medication.asp

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